

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025244

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 257 Primary Registration District No. 5880 Registrar's No. 16

STATE FILE NUMBER

FILED JUN 17 1963

1. PLACE OF DEATH a. COUNTY <u>Osage</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Gasconade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CRAWFORD Twp</u>		c. CITY OR TOWN <u>Owensville</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Linn Manor Rest Home</u>		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>Lillie Buckingham Spurgeon Rodgers</u>			4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6 1876</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Red Bird Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Allen Spurgeon</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Davis</u>		14. NAME OF HUSBAND OR WIFE <u>Albert Rodgers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>[redacted]</u>		
17. INFORMANT <u>Elsie Kohrman Kalamazoo Michigan</u>			Address		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Failure</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>[redacted]</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
---	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture left femur Mar 20, 1963</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>[redacted]</u>	
20c. TIME OF INJURY Hour <u>[redacted]</u> a.m. <u>[redacted]</u> p.m. <u>[redacted]</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>[redacted]</u>		20f. CITY, TOWN, OR LOCATION <u>[redacted]</u>	STATE <u>[redacted]</u>
21. Attended the deceased from <u>June 11</u> to <u>June 12</u> and last saw her alive on <u>June 12</u> Death occurred at <u>June 12</u> <u>3:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Norman W. Baldwin D.O.</u>		22b. ADDRESS <u>[redacted]</u>	22c. DATE SIGNED <u>6-14-63</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 15 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bowen</u>	23d. LOCATION (City, town, or county) (State) <u>Red Bird Mo</u>
24. FUNERAL DIRECTOR <u>Gottenstroeter Funeral Home</u> <u>Owensville Mo</u>		25. DATE RECD. BY LOCAL REG. <u>June 14 - 1963</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. L. de Martore</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Myford H. H. Winter

Licensed Embalmer No. 3838

P. O. Address OWENSVILLE

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.